PRE-PARTICIPATION HISTORY & PHYSICAL EXAM

Name:_____ Sex: ☐ F ☐ M Age:_____ Date of Birth: _____
Grade:_____ School:_____ Sport(s)**Please list ALL**: _____
Address:_____ Phone: _____
Personal Physician:_____ ☐ None
Emergency Contact :Name:_____ Relationship:_____ Phone#(s): _____

Attention parent or guardian and athlete: answers to the following questions are very important!!! **Please take the time, read through the questions, and answer to the best of your knowledge.**

General Medical History:

		YES	NO
1.	Do you have asthma?	☐	☐
2.	Do you have diabetes?	☐	☐
3.	Do you have high blood pressure?	☐	☐
4.	Do you have seizures?	☐	☐
5.	Do you have sickle cell trait?	☐	☐
6.	Do you have any other major medical problem?	☐	☐
7.	Have you ever been hospitalized or had surgery?	☐	☐
8.	Do you cough, wheeze or have trouble breathing with exercise?	☐	☐
9.	Do you use an inhaler?	☐	☐
10.	Do you have a single organ (testicle or kidney)?	☐	☐
11.	Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)?	☐	☐
12.	Have you ever taken any supplements or vitamins to help with weight loss, weight gain, or improve performance?	☐	☐
13.	Do you have any allergies (seasonal, insects, food, or medicines)?	☐	☐
14.	Have you ever had a rash or hives develop during or after exercise?	☐	☐
15.	Do you have any skin problems other than acne?	☐	☐
16.	Have you ever had a head injury, been knocked out, lost your memory, had your "bell rung," or a concussion?	☐	☐
17.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
18.	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
19.	Have you ever become ill from exercising in the heat?	☐	☐
20.	Have you had mononucleosis or any significant illness in the last 60 days?	☐	☐
21.	Do you have trouble with your eyes/vision/ wear glasses?	☐	☐
22.	Do you have trouble with your hearing/wear hearing aid(s)?	☐	☐
23.	Do you want to weigh more or less than you do now?	☐	☐
24.	Do you lose weight regularly to meet weight requirements for your sport or other reason?	☐	☐
25.	Do you feel stressed out, tired, or depressed?	☐	☐
26.	Are there any other issues you would like to discuss with the doctor?	☐	☐
27.	Are your immunizations up to date?	☐	☐

FEMALES ONLY

27.	Are your periods regular (every month)?	☐	☐
28.	Are your periods heavy?	☐	☐

Explain "YES" answers here ***(use back/page 2 if needed)*****:** _____

_____

_____

Cardiac History:

		YES	NO
1.	Have you ever passed out during or after exercise?	☐	☐
2.	Have you ever been dizzy during or after exercise?	☐	☐
3.	Have you ever had chest pain or chest pressure during or after exercise?	☐	☐
4.	Do you tire easily or more quickly than your friends during exercise?	☐	☐
5.	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
6.	Have you ever been told you had a heart murmur?	☐	☐
7.	Have you ever been told you had an enlarged or weak heart?	☐	☐
8.	Has any member of your family:		
	-died of heart problems or sudden death before age 50?	☐	☐
	-been told they had a serious heart problem before age 50?	☐	☐
	-been told they had Marfan's syndrome?	☐	☐
9.	Has a physician ever denied or restricted your participation in sports?	☐	☐

Explain "YES" answers here: _____

_____

_____

_____

Orthopaedic History:

		YES	NO
1.	Have you ever broken or fractured any bones?	☐	☐
2.	Have you ever subluxed or dislocated any joint?	☐	☐
3.	Have you had any other problems related to your:		
	-neck, spine, or back?	☐	☐
	-shoulders?	☐	☐
	-elbows?	☐	☐
	-wrists, hands, or fingers?	☐	☐
	-hips?	☐	☐
	-knees?	☐	☐
	-ankles, feet, or toes?	☐	☐
	-other?	☐	☐

Explain "YES" answers here ***(put date of injury if known)*****:** _____

_____

_____

_____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

PRE-PARTICIPATION SPORTS PHYSICAL EXAM

Vision: L20/_____R20/_____Both_____ Corrected: ☐Y ☐N BMI_____ (Wt in kg/ hgt in meters squared)

Height_____Weight_____Pulse_____B/P (R arm)_____

Medical	Normal	Abnormal Findings
Appearance/Emotional Affect		
Head/Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart (squatting to standing and supine)		
Pulses (include femoral)		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
Musculoskeletal	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

☐**May Participate in all sports, *EXCEPT* those listed below:**

_____

☐**May Participate after completing evaluation/rehabilitation for:** _____

_____

_____

☐**May Not Participate – Reason:** _____

_____

Recommendations: _____

_____

Signature of M.D. _____ **Date of Exam:** _____

Printed Name:_____ **Office Stamp**

Phone Number: _____

Extra Space for "YES" answers from the front: _____

_____

_____

_____

Developed 2003-2004 by the Richland County (South Carolina) School District One Task Force On Athletic Health Issues following a review of related information from the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, American Osteopathic Academy of Sports Medicine, the South Carolina High School League and the National Federation of State High School Associations. Revised 011807 by the SCMA Medical Aspects of Sports Committee